

1993

PATERNALISM AND THE UNREALIZED PROMISE OF ESSAYS IN THERAPEUTIC JURISPRUDENCE

John Petriola

Follow this and additional works at: https://digitalcommons.nyls.edu/journal_of_human_rights



Part of the [Law Commons](#)

Recommended Citation

Petriola, John (1993) "PATERNALISM AND THE UNREALIZED PROMISE OF ESSAYS IN THERAPEUTIC JURISPRUDENCE," *NYLS Journal of Human Rights*: Vol. 10 : Iss. 3 , Article 11.

Available at: https://digitalcommons.nyls.edu/journal_of_human_rights/vol10/iss3/11

This Book Review is brought to you for free and open access by DigitalCommons@NYLS. It has been accepted for inclusion in NYLS Journal of Human Rights by an authorized editor of DigitalCommons@NYLS.

BOOK REVIEW

Paternalism and the Unrealized Promise of ESSAYS IN THERAPEUTIC JURISPRUDENCE.

A review of ESSAYS IN THERAPEUTIC JURISPRUDENCE

By David B. Wexler & Bruce J. Winick

Durham, North Carolina

Carolina Academic Press (1991)

Pp. 322

*Reviewed by John Petrila. **

In *Essays in Therapeutic Jurisprudence*,¹ David Wexler and Bruce Winick argue that mental disability law has too long ignored the consequences of the rules it establishes. In their view, academicians and practitioners interested in mental disability law have focused almost exclusively on questions of ideology and rights, forfeiting valuable examination of the outcomes caused by judicial and legislative decisions. In attempting to eliminate the intellectual "sterility" which they believe characterizes mental disability law, they propose therapeutic jurisprudence as a way to examine "the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences."²

In practice, this would result in a much greater reliance by legal decision makers on empirical data produced by social scientists:

"Legal judgments . . . are often based on factual predicates that remain unexamined empirically and that might turn out not to be true. . . . Our aim is to

© Copyright 1993 by the *New York Law School Journal of Human Rights*.

* Chairman, Department of Mental Health Law and Policy, University of South Florida. The author acknowledges and thanks Mr. Harold Mayo for his review and comments on an earlier draft of this review.

¹ ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick, eds., 1992).

² David B. Wexler & Bruce J. Winick, *Introduction* to ESSAYS, *supra* note 1, at ix.

suggest that legal decision makers explicitly take account of this impact, that they become more sophisticated about and make better use of the insights and methods of the behavioral sciences, and that social scientists audit law's success or failure in this regard."³

Wexler and Winick describe their mission in rather modest terms: therapeutic jurisprudence "simply seeks to focus attention on an often neglected ingredient in the calculus necessary for performing a sensible policy analysis of mental health law and practice—the therapeutic dimension—and to call for a systematic empirical examination of this dimension."⁴ Despite this modest claim, they believe that therapeutic jurisprudence principles have general applicability far beyond mental disability law and "will also have applications in forensic psychiatry generally, in health law, in a variety of allied legal fields (criminal law, juvenile law, family law) and probably across the entire legal spectrum."⁵

While there is no evidence that courts have as yet been responsive to therapeutic jurisprudence,⁶ it has struck a responsive chord among academicians. *Essays* has garnered high praise from some of the leading figures in the mental disability law field,⁷ and a

³ *Id.* at xi.

⁴ *Id.*

⁵ *Id.* at x.

⁶ A Lexis search performed on Oct. 25, 1993, searching all federal and state court cases for the term "therapeutic jurisprudence" found no cases. At the same time, it is evident that courts attempt to examine the impact of their decisions on individuals without using the label created by Wexler and Winick. See *infra* note 10 and accompanying text. But see Liz Balmaseda, *Two Judges Use Therapy to Curb Home Violence*, MIAMI HERALD, Apr. 7, 1993, at 1B (reporting that Judges Cindy Lederman and Linda Dakis use "therapeutic jurisprudence" in applying innovative remedies from the bench to break the cycle of domestic violence).

⁷ *ESSAYS*, *supra* note 1, at jacket (containing praise from a number of leading academicians in the mental disability law field). John Monahan writes that "what mental health law craves are new ideas, and *Essays in Therapeutic Jurisprudence* is brimming with them . . . two of the most creative scholars in the field have produced a work that can genuinely be called exciting." *Id.* Paul Appelbaum claims that "therapeutic jurisprudence is a tonic for what ails mental health law . . . [it] will set the agenda for the next generation of reform in the civil and criminal systems that deal with the

literature devoted to the subject of therapeutic jurisprudence is emerging.⁸

The popularity of therapeutic jurisprudence among academicians may be attributable in part to its seemingly undeniable logic. The argument that people involved in the development of mental disability law (or for that matter any area of law) should examine the consequences of legal rules, principles, and procedures, is difficult to dispute.

At the same time, therapeutic jurisprudence may be criticized on a number of grounds. First, academicians and others (including people who have received treatment in the mental health system) may dispute the assumption that an attempt to obtain therapeutic outcomes should play a dominant (or for that matter any) role in judicial decision making.⁹ Second, the claim that therapeutic jurisprudence represents a new way of thinking about disability issues seems overstated; as the authors acknowledge, the United States Supreme Court has given at least lip service to the idea that legal principles established in mental disability litigation should consider whether

mentally ill." *Id.* Richard Bonnie writes that "these essays will leave an enduring mark on the field." *Id.* Wexler describes therapeutic jurisprudence as a "fresh approach to mental health law." *Id.* See Jeffrey A. Klotz et al., *Cognitive Restructuring Through Law: A Therapeutic Jurisprudence Approach to Sex Offenders and the Plea Process*, 15 U. PUGET SOUND L. REV. 579, 579 n.1 (1992) (citing *Essays* as providing "concrete illustrations and applications of the approach.").

⁸ See Robert F. Schopp, *Therapeutic Jurisprudence and Conflicts Among Values in Mental Health Law*, 11 BEHAVIORAL SCI. & L. 31, 32 (1993) (supporting the use of empirical data in legal decision making, but acknowledging the fact that "empirical premises alone cannot determine the correct choice."); David B. Wexler, *Therapeutic Jurisprudence and Changing Conceptions of Legal Scholarship*, 11 BEHAVIORAL SCI. & L. 17, 29 (1993) (tracing the parallel between questions asked by therapeutic jurisprudence scholars and those asked by public law scholars); David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225, 225 (1992) (illustrating the application of therapeutic jurisprudence to criminal justice/mental health issues); see also Mark A. Small, *Legal Psychology and Therapeutic Jurisprudence*, 37 ST. LOUIS U. L.J. 675 (1993).

⁹ See *infra* note 38 and accompanying text.

those principles will have a therapeutic impact.¹⁰ In addition, other

¹⁰ *Parham v. J.R.*, 442 U.S. 584 (1979) (upholding the constitutionality of a Georgia law, in considering voluntary admission of a ward of the state by the Department of Family and Children Services to Central State Regional Hospital (a mental health institution), which provided at that time:

The superintendent of any facility may receive for observation and diagnosis . . . any individual under 18 years of age for whom such application is made by his parent or guardian. . . . If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.

GA. CODE ANN. § 88-503.1 (1975)). The decision permitted civil commitment of children without judicial hearing in part because of the concern of the majority that the imposition of judicial process might impede the treatment of children. *Parham*, 442 U.S. at 610. Writing for the majority, Chief Justice Burger noted that:

Moreover it is appropriate to inquire into how such a hearing would contribute to the successful long-range treatment of the patient. Surely, there is a risk that it would exacerbate whatever tensions already exist between the child and the parents. Since the parents can and usually do play a significant role in the treatment while the child is hospitalized and even more so after release, there is a serious risk that an adversary confrontation will adversely affect the ability of the parents to assist the child while in the hospital.

Id. at 610. *But see* Michael L. Perlin, *An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger's 'Time-Consuming Procedural Minuets' Theory in Parham v. J.R.*, 9 BULL. AM. ACAD. PSYCHIATRY & L. 149 (1981) (disagreeing with the Court's logic). Perlin criticizes the Supreme Court's omission of "supporting citation, reference to the court record or analysis of behavioral research" in light of the fact that it "embraced the basic propositions proffered by *amicus* American Psychiatric Association (APA) without much consideration of its supporting data. On the other hand, it totally failed to acknowledge, consider, deal with or rebut the data presented by another *amicus*, the Division of Mental Health Advocacy of the New Jersey Department of the Public Advocate." *Id.* at 152-53 (footnotes omitted). The *amicus curiae* brief submitted by the APA concluded that psychological harm would be inflicted upon the child during due process hearings because of "the unique emotion-laden nature of the parent-child conflicts" that would be aired, basing its conclusions on several cited articles considering the traumatic effect of hospitalization on parents; in contrast the *amicus curiae* brief submitted by the Division of Mental Health Advocacy of the New Jersey Department of Public Advocacy highly recommended due process hearings based upon experience in providing legal representation of juveniles facing involuntary civil commitment proceedings, accumulated statistics, and records of dispositions acquired since 1975. *Id.* at 154-56 (footnotes omitted).

academicians have expressed similar views under different labels.¹¹

Third, a close reading of therapeutic jurisprudence, particularly as it is presented in *Essays*, suggests that the uncritical enthusiasm with which therapeutic jurisprudence has been embraced should be tempered by more critical analysis of the key assumptions made by Wexler and Winick. The core premise of *Essays* is an assumption of "general agreement that, *other things being equal*, mental health law should be restructured to better accomplish therapeutic values."¹² As will be discussed in more detail below, this assumption is questionable. In addition, in making this assumption, the authors ignore the emerging consumer/survivor movement in mental health, which challenges the basic premises upon which mental health policy, practice, and law rest. Academicians, researchers, lawyers, and mental health professionals may agree that the premise that the law should seek therapeutic outcomes is an article of faith while those most affected by the law and mental health practice may strongly disagree.

Significantly, *Essays* fails to question *who decides* what represents a therapeutic outcome. Instead, *Essays* simply assumes that research scientists and lawyers will decide whether a particular legal rule or intervention has therapeutic value. People treated voluntarily or coercively by mental health professionals and subject to legal rules governing the conditions and terms of that treatment are largely ignored. As a result, people who can provide the best information about the therapeutic or antitherapeutic consequences of legal/therapeutic interventions are excluded from participating in the analysis of what is or is not in their interest. Therapeutic jurisprudence as it has been conceptualized to date is a conservative, arguably paternalistic, approach to mental disability law. It relegates to research psychologists and lawyers decision making authority over issues of critical importance to individuals who find themselves the subject of mental health treatment and legally sanctioned coercion.

¹¹ See Craig Haney, *Psychology and Legal Change: The Impact of A Decade*, 17 LAW & HUM. BEHAV. 371 (1993) (reviewing the literature on psychology and its potential contribution to law and discussing the need for the law and psychology field to become more inclusive in its perspective). Haney welcomes other points of view, particularly from feminists and racial minorities. *Id.* at 387-92.

¹² *Introduction, supra* note 2 at xii.

In its current state therapeutic jurisprudence, while often cloaked in the language of autonomy and choice, simply reinforces the existing distribution of power in the relationship between treater and treated. In some critical areas it would result in even more power accruing to professional interests. Until this core problem is addressed, therapeutic jurisprudence will have little if any practical impact on many of the questions its authors would like to address and as a concept one may reasonably predict that it will be actively resisted by many in the consumer/survivor movement as simply another in a long series of efforts to assure continued professional dominance over mental health services and disability law.

Book Contents

Essays in Therapeutic Jurisprudence is a collection of essays authored by Wexler, Winick, and Robert F. Schopp, either together or individually, which explore applications of the principles of therapeutic jurisprudence to a variety of legal topics. Like an earlier work by Wexler on the same topic,¹³ most of the material has been published elsewhere.

The book is divided into five parts. Part I, entitled *Toward a Therapeutic Jurisprudence*, consists of two chapters in which Wexler establishes the rationale and conceptual framework for therapeutic jurisprudence. In Chapter 1, Wexler argues that mental health law has been largely "doctrinal, constitutional, and rights-oriented," an approach which is heavily dependent on judicial decisions setting forth constitutional principles.¹⁴ In Wexler's view this approach is "both risky and, after twenty years, sterile."¹⁵ Wexler believes that as a result of the ideological conflicts which governed mental disability law in its early phases, lawyers and judges lack trust in mental health professionals, which in turn has led to a reluctance to consider behavioral science contributions in articulating and

¹³ THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David B. Wexler, ed., 1990).

¹⁴ David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, in ESSAYS, *supra* note 1, at 3.

¹⁵ *Id.* at 5.

evaluating the consequences of legal principles.¹⁶ Therapeutic jurisprudence, "the study of the role of the law as a therapeutic agent," is his antidote.¹⁷ This chapter concludes with a description of the format of a "paradigmatic therapeutic jurisprudence piece written by an academic lawyer."¹⁸

In Chapter 2 Wexler describes four overlapping areas of inquiry for therapeutic jurisprudence.¹⁹ These include the role of the law in producing psychological dysfunction; therapeutic aspects of legal rules; therapeutic aspects of legal procedures; and therapeutic aspects of judicial and legal roles. He uses a variety of examples, including civil commitment and treatment of people found incompetent to stand trial, to suggest ways in which inquiry by behavioral scientists may lead to more informed judgments regarding the therapeutic consequences of legal rules and processes.

¹⁶ "The lesson—learning to be skeptical of supposed scientific expertise—is an important one, and I doubt the law will ever again simply *defer* to psychiatry and the related disciplines." *Id.* at 7. *But see* *Youngberg v. Romeo*, 457 U.S. 307, 322-24 (1982) (announcing that courts were to defer to professional judgment in litigation involving the rights of people who were institutionalized in state mental disability facilities). *Cf.* Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 *YALE L.J.* 639 (1992) (describing professional judgment as a standard that the Court does not truly understand).

Courts . . . bas[e] the professional judgment standard on a powerful mythology about professionals in the private sphere, but almost always apply it in a public sector context. The Court's image of freely chosen professional-client interaction is thus transplanted to institutional settings where the professionals are state actors, the professional-client relationship is permeated with state concerns and conflicts of interest, and the clients are an indigent and captive population.

Id. at 644.

¹⁷ David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, in *ESSAYS*, *supra* note 1, at 8.

¹⁸ A typical article written in a therapeutic jurisprudence framework will include an introduction, a description of applicable law, a discussion of relevant psychological principles and findings, application of psychological principles and findings to the legal matter at issue, and a conclusion. Wexler, *supra* note 14, at 13-14.

¹⁹ David B. Wexler, *An Introduction to Therapeutic Jurisprudence*, in *ESSAYS*, *supra* note 1, at 17.

Part II of the book includes two chapters written by Bruce Winick.²⁰ In these chapters Winick develops an argument for utilizing a model of competency which in most situations would presume that a person being treated or seeking treatment for mental illness is competent to make such a decision. A formal adjudication of competency would occur only if the person objected to treatment, or if it was decided (by whom is not clear) that the proposed treatment or intervention may be sufficiently risky and the person's competency sufficiently marginal that an inquiry into competency would be conducted.²¹ As the discussion below suggests, these chapters rest on assumptions about the operation of the mental health system and the relationship between treater and treated that are suspect at best.

In Part III, David Wexler, collaborating with Robert Schopp, examines the problem of hindsight bias in the tort system. In Chapter 5 they discuss two proposals for ameliorating the problem of hindsight bias by fact finders in malpractice litigation.²² They suggest that the elimination of hindsight bias may be more important in some types of cases than in others, contrasting malpractice cases where suicide by prescribed medication has occurred with negligent release cases in which violence toward another has resulted. Chapter 6

²⁰ Bruce J. Winick, *Competency to Consent to Treatment: The Distinction between Assent and Objection*, in ESSAYS, *supra* note 1, at 41 [hereinafter *Competency to Consent to Treatment*]; Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch*, in ESSAYS, *supra* note 1, at 83 [hereinafter Winick, *Competency to Consent to Hospitalization*].

²¹ Winick, *Competency to Consent to Treatment*, *supra* note 20, at 51-67.

²² David B. Wexler & Robert F. Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Malpractice Litigation: Some Preliminary Observations*, in ESSAYS, *supra* note 1, at 135. See Harold Bursztajn et al., "Magical Thinking," *Suicide, and Malpractice Litigation*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 369 (1988). One solution to the disadvantage of "determination[s] made in retrospect" in negligence litigation cases is "a carefully documented risk-benefit analysis shared with the patient through the informed consent procedure." *Id.* at 369, 375 (footnote omitted). See also Norman G. Poythress Jr., *Negligent Release Litigation: A Proposal for Procedural Reform*, 17 J. PSYCHIATRY & L. 595, 600-03 (1989) (suggesting bifurcated proceedings to allow juries to rule separately on negligence and harm inquiries).

continues the discussion of malpractice litigation and the tort system.²³ Wexler and Schopp argue that efforts by mental health professionals to establish clear standards of care in areas susceptible to malpractice litigation may subvert both the therapeutic outcomes sought by the mental health system and the goals of the legal system.²⁴ Briefly, Schopp and Wexler argue that if fixed standards of care are established, mental health professionals in their desire to adhere to such standards (thereby enjoying some presumed insulation from malpractice judgments) may act according to their own, rather than their patients', interest in making certain judgments. This in turn would undermine their view of the law's goal in applying tort principles as the reinforcement of the fiduciary relationship between treater and treated.²⁵

²³ Robert F. Schopp & David B. Wexler, *Shooting Yourself in the Foot with Due Care: Psychotherapists and Crystallized Standards of Tort Liability*, in *ESSAYS*, *supra* note 1, at 157.

²⁴ In recent years, efforts by psychiatry and other branches of medicine to create "practice standards" or "practice guidelines" have increased, both in response to malpractice litigation and to cost-containment efforts by insurers. *See, e.g.*, AMERICAN PSYCHIATRIC ASSOCIATION, PRACTICE GUIDELINES FOR EATING DISORDERS, 150 AM. J. PSYCHIATRY 207 (1993); AMERICAN PSYCHIATRIC ASSOCIATION, PRACTICE GUIDELINES FOR MAJOR DEPRESSIVE DISORDER IN ADULTS, 150 AM. J. PSYCHIATRY (Supp. 1993); CONSENSUS DEVELOPMENT CONFERENCE PANEL, DIAGNOSIS AND MANAGEMENT OF ASYMPTOMATIC PRIMARY HYPERPARATHYROIDISM: CONSENSUS DEVELOPMENT CONFERENCE STATEMENT, 114 ANNALS OF INTERNAL MED. 593 (1991); Seymour Perry, *The NIH Consensus Development Program: A Decade Later*, 317 NEW ENG. J. MED. 485, 485 (1987) (discussing the effects of the 1977 National Institute of Health (NIH) program report calling for technology assessment to reduce health care costs and improve health care quality). Some states have mandated the creation of practice standards as part of legislative efforts to regularize practice. *E.g.*, FLA. STAT. ANN. § 408.02 (West 1992) (directing state government, working with the state medical associations, to adopt and implement "scientifically sound medical practice parameters for their respective practices in the state to eliminate unwarranted variations in the delivery of health care." In developing these parameters, the state was to use "reliable methodologies that integrate relevant research findings" and utilize "appropriate clinical expertise" as well. The parameters, once developed, are to be distributed to physicians and other providers across the state, and are to be used as well in conducting utilization review in the Medicaid program. FLA. STAT. ANN. § 408.02(1) (West 1992)).

²⁵ Schopp and Wexler argue that in cases other than assault on a patient and other egregious conduct "both professional organizations and courts should refrain from establishing . . . concrete professional rules or crystallized legal duties" because therapists will then attempt to conform their conduct to those rules and risk acting in their own rather than their client's interests. Schopp & Wexler, *supra* note 23, at 182-83. The authors also argue that as a general rule, courts should adopt as the relevant

Part IV, called *Marshalling Motivation: Threats, Contracts, and Wagers*, consists of three chapters devoted to applying various behaviorist theories to assure better compliance with treatment regimens. In Chapter 7 Wexler suggests using a criminal charge of reckless endangerment against people on conditional release or

standard in tort litigation the standard of "ordinary care and competence" provided by a member in good standing within the profession. *Id.* at 161. The authors come close to an argument that mental health professionals should be exempt from ordinary tort principles suggesting that "[a]t first glance, these arguments may seem to generate the intuitively implausible claim that no one should ever be held liable in tort for violating a fiduciary duty." *Id.* at 174. While not arguing for an exemption, Schopp and Wexler do counsel almost complete deference to professional views as to what constitutes acceptable treatment, based on the assumption that the tort system should operate to reinforce the fiduciary responsibilities of treater to the person in treatment. *Id.* While this may be one goal of the tort system, it is certainly not the only one nor is it even the primary one. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS §1, at 6 (5th ed. 1984) ("The law of torts, then, is concerned with the allocation of losses arising out of human activities. . . . 'The purpose of the law of torts is to adjust [these] losses, and to afford compensation for injuries sustained by one person as the result of the conduct of another.'").

Some readers may find this chapter problematic in other ways. For example, Schopp and Wexler use the term "psychotherapy" as roughly synonymous with "mental health care." *Id.* at 160 n.8. This is an uncommonly broad use of that term. The authors rest their argument for deference in part on the statement that "outcome research increasingly supports the contention that psychotherapy produces statistically significant and clinically meaningful improvements for patients. These positive results tend to last and to exceed the effects of placebo or pseudo-therapy control groups." *Id.* at 173. *Contra* MARTIN L. GROSS, THE PSYCHOLOGICAL SOCIETY: THE IMPACT—AND THE FAILURE—OF PSYCHOTHERAPY, PSYCHOANALYSIS AND THE PSYCHOLOGICAL REVOLUTION (1978). Gross discusses research studies that conclude that psychotherapy "has only little, or modest healing powers." *Id.* at 24-31. He quotes Dr. Lester Luborsky of the University of Pennsylvania in his opinion that "[i]t cannot be determined whether the type of individual who profits most would also have profited from another form of treatment or from change-inducing experiences which usually are not designated as psychotherapy—or indeed from nothing more than the mysterious change attributed to the passage of time." *Id.* at 54. *See, e.g.*, Janice L. Krupnick & Harold A. Pincus, *The Cost-Effectiveness of Psychotherapy: A Plan for Research*, 149 AM. J. PSYCHIATRY 1295 (1992). Mental health professionals have experienced increased difficulty in obtaining reimbursement for their services because of a paucity of data which could convince payers of care that the cost effectiveness of those services has been demonstrated. *Id.* Krupnick and Pincus recognize the need for research in the area of cost-effectiveness in the area of psychotherapy to meet an increasing demand for accountability by governmental bodies, to serve as a guide to clinical practice, and to provide a basis for informed policy and reimbursement decisions, for example, in speeding recovery and shortening hospital stays for cardiac patients. *Id.* at 1302.

outpatient status who decline to take their medication.²⁶ He argues that negative consequences may occur if a person does not take medication that has been prescribed, urging that criminal law reckless endangerment statutes be applied to such situations as they are in other cases, for example, when people diagnosed as alcoholics do not follow treatment regimens designed to prevent harm. Wexler focuses on those "who have a history of violent behavior when they fail to take antipsychotic medication."²⁷ While some people who have been diagnosed as schizophrenic may present a danger to others in some circumstances (as do other people with other characteristics) his arguments ignore reports from psychiatrists that people decline to take prescribed medication for a variety of reasons.²⁸ In Chapter 8 Wexler describes a series of principles developed in the general health system designed to increase adherence to prescribed treatment.²⁹ He then applies the principles to two alternative forms of monitoring the status and treatment adherence of individuals conditionally released after acquittal by reason of the insanity defense. In some jurisdictions judges oversee the release process, while in others that function is performed by an administrative board. Wexler speculates that the judicial model may be superior to the administrative model because it permits the judge to reinforce for the individual the importance of following the prescribed treatment regimen.³⁰

Part IV concludes with Chapter 9, the longest chapter in the book.³¹ In this chapter, Winick argues that government should use the "psychological power of the bet" to accomplish a variety of social goals. In his scheme, government would "wager" with citizens in an effort to achieve particular outcomes. For example, individuals could

²⁶ David B. Wexler, *Inducing Therapeutic Compliance Through the Criminal Law*, in *ESSAYS*, *supra* note 1, at 187.

²⁷ Wexler, *supra* note 26, at 193.

²⁸ PAUL S. APPELBAUM & THOMAS GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 114-19 (2d ed. 1991) (noting that "origins of treatment refusal are manifold").

²⁹ David B. Wexler, *Health Care Compliance Principles and the Insanity Acquittee Conditional Release Process*, in *ESSAYS*, *supra* note 1, at 199.

³⁰ *Id.* at 217-18.

³¹ Bruce J. Winick, *Harnessing the Power of the Bet: Wagering with the Government as a Mechanism for Social and Individual Change*, in *ESSAYS*, *supra* note 1, at 219.

choose to "bet" the government regarding their eventual completion of a program designed to address drug addiction. If a citizen chose voluntarily to enter this arrangement, he or she could "win" money or other rewards established by government by reaching the goal agreed upon at the start. Conversely, if the person failed ("lost the bet") he or she would suffer an agreed upon consequence.³²

In Part V, Teaching and Research, Wexler makes a series of interesting observations about revitalizing the teaching of mental disability law through use of therapeutic jurisprudence principles.³³ He describes a number of traditional law/mental health issues that might be re-examined "using the therapeutic jurisprudence lens."³⁴ These include the right to refuse treatment, treatment for incompetent death row inmates, and treatment for incompetency to stand trial. Wexler ends this chapter, and the book, by arguing that the use of therapeutic jurisprudence will result in an international research agenda in mental disability law by creating a framework for the pursuit of multi-national research.

Comments

The authors apply therapeutic jurisprudence principles to a broad range of legal issues. In many cases an analysis using therapeutic jurisprudence principles may yield more informed outcomes than might otherwise occur when legal principles are based wholly on anecdotal or case-specific information. The authors also make clear that they do not intend that the law be given over wholly to research scientists; they acknowledge that in certain circumstances normative constitutional principles should prevail regardless of what social science research suggests about the therapeutic or

³² This chapter does not define what the person would lose or by what process, nor does it discuss the unequal bargaining power that government would have relative to an individual who in many of the examples Winick uses would lack economic or other resources that would make "entering the wager" truly voluntary.

³³ David B. Wexler, *Training in Law and Behavioral Sciences: Issues from a Legal Educator's Perspective*, in *ESSAYS*, *supra* note 1, at 293.

³⁴ *Id.*

antitherapeutic consequences of those principles.³⁵ The chapters written by Winick stress the legal and clinical importance of the values of autonomy and voluntariness as principles that should govern decision making by individuals with mental disability.

However, *Essays* falls short when it suggests therapeutic jurisprudence can reinvigorate mental disability law, because it does nothing to challenge professional domination of mental disability law and treatment. It fails to take account of the growing challenge to professional hegemony represented by the consumer/survivor movement in mental health³⁶ and relies upon a set of assumptions which warrant close examination. These assumptions may be characterized as described below.

³⁵ Wexler explains "[w]e do not suggest that all constitutional restrictions be open to reconsideration in light of the results of a therapeutic jurisprudence assessment. Many constitutional rules—*Ford v. Wainwright's* ban of execution of a person found to be incompetent, for example—will be fully justified on normative grounds even if they produce negative therapeutic consequences." David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Research Tool*, in *ESSAYS*, *supra* note 1, at 320 (footnote omitted); *Ford v. Wainwright*, 477 U.S. 399 (1986) (reversing State decision inflicting the death penalty upon an insane prisoner as a violation of the Due Process Clause and the Eighth Amendment). Discussing the *Wainwright* holding, Wexler defines the operative normative principle as "the notion that it does not comport with human dignity to execute a defendant who is so mentally ill that he is unable to understand and appreciate why he is being put to death." Wexler & Winick, *supra*, at 313. One of the difficulties with the approach to therapeutic jurisprudence outlined in *Essays* is that the authors provide few criteria other than vaguely defined "normative principles" like that noted as the justification for the Court's ruling in *Wainwright*. As a result, the application of therapeutic jurisprudence principles appears somewhat arbitrary and dependent on the subjective preferences of people writing about it.

³⁶ The nomenclature used to describe people who have been treated in or confined by the mental health system has become an issue. Some publications use terms like "survivor," "consumer," "user," and "client" interchangeably. See MARY O'HAGAN, *STOPOVERS ON MY WAY HOME FROM MARS: A WINSTON CHURCHILL FELLOWSHIP REPORT ON THE PSYCHIATRIC SURVIVOR MOVEMENT IN THE USA, BRITAIN AND THE NETHERLANDS* (1991). Mental patients' liberation groups "develop[ed] different terminologies to describe themselves and their work" including but not limited to "ex-patient," "ex-psychiatric inmate," "client," "consumer," or "psychiatric survivor." Judi Chamberlin, *The Ex-Patients' Movement: Where We've Been and Where We're Going*, 11 J. MIND & BEHAV. 323, 326-28 (1990). The differences in terminology reflect the differing priorities and emphases of the users: those calling themselves "inmates" or "survivors" generally adopt a more militant stance toward the mental health system. *Id.* The phrase used most frequently in *Essays* to describe people who have been diagnosed as mentally ill is the phrase "mental patient," a phrase exclusively used by professionals.

First, as noted earlier, the authors assume "general agreement that, *other things being equal*, mental health law should be restructured to better accomplish therapeutic values."³⁷ This assumption on its face is highly questionable. Criticisms of the "therapeutic state" are common in both popular and professional literature;³⁸ the views of people who do not share the belief that law should be devoted to accomplishing therapeutic values should not simply be discounted. *Essays* also fails to articulate clear decision rules for determining when "other things are equal" and whether and under what circumstances therapeutic values must yield to other values.³⁹ As a result *Essays* assumes the triumph of therapeutic values in ways that appear to be arbitrary. For example, in arguing for a model of decisionmaking that would presume the competency of the individual, Winick writes:

³⁷ Wexler & Winick, *supra* note 2, at xii.

³⁸ LOUISE ARMSTRONG, *AND THEY CALL IT HELP* (1993) (describing in highly critical terms the explosion of psychiatric hospitalization of children that occurred in the 1980's, principally in private, for profit, psychiatric hospitals). Armstrong reveals the trials and tribulations of those who have been abused in the psychiatric system (whom she labels psychiatric survivors). *Id.* at 3-4. The book relies heavily on accounts gathered from children who had been hospitalized, recounts the concerted efforts of hospitals and other providers to gain patients, and expounds the U.S House of Representatives Select Committee on Children, Youth, and Families hearing entitled *The Profits of Misery: How Inpatient Psychiatric Treatment Bilks the System and Betrays Our Trust*, chaired by Representative Pat Schroeder. *Id.* at 265-71. See also *CRY OF THE INVISIBLE* (Michael Susko ed. 1991) (detailing encounters by homeless persons who have been diagnosed as mentally ill); THOMAS S. SZASZ, *LAW, LIBERTY AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES* 39 (1968) (characterizing commitment proceedings as an example of how "commitment serves the institutional values of psychiatry as a system of social control. . . . Its controlling function is hidden under a facade of medical and psychiatric jargon, and is buttressed by a self-proclaimed desire to help or treat so-called mentally ill persons." *Id.*); THOMAS S. SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* 296 (1961) [hereinafter *THE MYTH OF MENTAL ILLNESS*] (denying the existence of mental illness and defining psychiatrists concerns as "deal[ing] with personal, social and ethical problems in living."). See generally Symposium, *Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental Health System*, 11 *J. MIND & BEHAV.* 247 (1990) (challenging a variety of mental health practices in a diverse collection of articles).

³⁹ See *supra* note 35.

The presumption of competency attaching to the expression of choice would be rebuttable and vary with the degree of autonomy present and the risk/benefit ratio of the intervention the individual seeks to elect. When, for example, the risk/benefit ratio is highly questionable, it may be appropriate to find a marginally competent individual incompetent and prevent him from acting in accordance with his expressed preference.⁴⁰

This is an argument that autonomy will be honored as a core value and the individual will be permitted to exercise choice only until others decide that even a "marginally competent" individual has chosen badly. Such a result is arbitrary (there are no stated, objective rules for determining when the "marginally competent" person will lose the power to decide) and paternalistic (the person loses the power to decide when someone else will decide that it is appropriate for her to lose it). While this may be well-intended paternalism it is paternalism nonetheless. It suggests that *Essays* does not articulate the discernible limits on the exercise of therapeutic values that it endorses.

Second, *Essays* fails to answer the more important question of *who decides* what constitutes a therapeutic outcome. While Wexler and Winick do not address this point directly, they suggest at least implicitly that research scientists and lawyers sensitive to research data will make such decisions. In concluding Part I, which establishes the rationale for pursuing a therapeutic jurisprudence agenda, Wexler writes:

[I]n the aftermath of [therapeutic jurisprudence] research and thinking, the accumulated body of knowledge may be useful to practicing legal and mental health professionals. Indeed, with such knowledge, the professionals might strive together to

⁴⁰ Winick, *Competency to Consent to Treatment*, *supra* note 20, at 66.

reform the law and the legal system to help counteract mental illness and to help promote mental health.⁴¹

While the authors suggest several times that the legal system should consider but not simply defer to research conclusions regarding the therapeutic value of certain legal principles or processes some of their other suggestions are contradicting. While arguing for a departure by lawyers from an adversarial role in some circumstances, Wexler writes:

[L]awyers may, for example, ask a client to consider whether the pursuit of a certain grievance is in actuality an attempt to resist therapy.

For lawyers properly to play such a role, however, further work needs to be performed in marshalling mental health insights, in documenting the extent to which lawyers can be trained to function as therapeutic agents, and in examining the ethical implications of that revised role.⁴²

While the suggestion that lawyers on occasion may and should abandon a reflexively adversarial role may have merit,⁴³ the more

⁴¹ David B. Wexler, *An Introduction to Therapeutic Jurisprudence*, in *ESSAYS*, *supra* note 1, at 38.

⁴² *Id.* at 36-37.

⁴³ See David B. Wexler, *MENTAL HEALTH LAW: MAJOR ISSUES* 99 (1981) (suggesting that counsel thoroughly study the facts of the case; communicate with the patient, family, and friends; fully understand the events preceding the filing of the petition; investigate the patient's and family's financial conditions; and explore the treatment and custodial resources of the community, ensuring application of resources to "meet the needs of the client as alternatives to involuntary commitment."); Samuel J. Brakel, *Legal Aid in Mental Hospitals*, 1981 AM. B. FOUND. RES. J. 23, 93 (1981) (illuminating the role of law and lawyers "in improving the treatment of the mentally ill" or "of doing considerable damage" through a comparison of studies from several states); Robert D. Miller et al., *Litigiousness as a Resistance to Therapy*, 14 J. PSYCHIATRY & L. 109, 119 (1986) (footnote omitted) (describing "how adversarial legal proceedings can reinforce adolescent's resistance to therapy by supporting their challenges to authority as represented by their therapists. On the other hand, when advocates recognize the resistance involved in some grievances, they can provide significant assistance. . . . Patients will often accept interpretations from attorneys or advocates when they won't listen to clinical staff.").

important point that needs critical examination is the assumption that lawyers and mental health professionals should act in concert to identify and promote therapeutic values as one of the core functions of the legal system.

These two assumptions rest in turn on a third assumption, which informs many of the major conclusions of *Essays*. This is the assumption that in virtually all circumstances the legal system should defer to the prescriptions of treaters. The rationale for this conclusion, discussed most comprehensively in the chapters on assent and voluntary admissions, is that physicians have a fiduciary duty to their patients and therefore it generally may be assumed absent an objection by the patient that the proposed treatment is in the person's best interest.⁴⁴ In the model of consent and competency proposed by Winick, individuals generally would be considered competent unless objecting to a decision by a mental health professional. He argues:

Other than in contexts in which a high possibility of conflict of interest between physician and patient exists, the physician's recommendation provides strong evidence that the risk/benefit ratio of the patient's choice is an acceptable one and that the patient's decision is thus not unreasonable. . . . We should hesitate to interfere with a patient's assent to a treatment recommended by his physician since the physician's recommendation ordinarily provides rather strong evidence that the patient's choice, rather than being injurious to his welfare, will further it.⁴⁵

This characterization of the physician-patient relationship underlies his arguments in the chapter on voluntary hospitalization as well.⁴⁶ This chapter is a critique of the decision by the United States

⁴⁴ Winick's chapters are discussed in detail because they rely explicitly on an idealized model of the mental health system and treatment relationship permitting a conclusion that prescriptions of treaters should generally receive deference from the legal system. Wexler's chapters support the same conclusion.

⁴⁵ Winick, *Competency to Consent to Treatment*, *supra* note 20, at 66-67 (footnotes omitted).

⁴⁶ *See id.* at 83-134.

Supreme Court in *Zinermon v. Burch*.⁴⁷ In *Zinermon*, the Supreme Court held that an individual who had admitted himself voluntarily to a Florida state psychiatric hospital could bring a federal civil rights action alleging that his rights had been violated when the hospital did not inquire into his competency to admit himself voluntarily to the hospital.⁴⁸ Winick focuses on dicta in the Court's decision which appears to impose an obligation upon states to inquire into a person's competency as a condition of voluntary admission.⁴⁹ Concerned that this will impose an unduly high standard of competency thereby discouraging voluntary admissions, he proposes instead a model which he believes would encourage voluntary admissions, noting that "[t]here is considerable value in allowing patients to choose hospitalization voluntarily, rather than imposing it upon them. Indeed, making patients feel that the decision has been made for them could undermine the therapeutic value of choice."⁵⁰ Winick concludes that an informal review of the competency of the person seeking admission will suffice to protect people against unwarranted admissions, and argues that the cost of an erroneous admission is not high. After reviewing the risks of error to the individual in other contexts (for example, the erroneous admission of a child to a psychiatric hospital or an erroneous injection of medication) he concludes:

⁴⁷ 494 U.S. 113 (1990) (deciding whether or not an individual's rights were violated when he voluntarily admitted himself to a mental health facility while in a confused state during which he was largely unaware of his surroundings).

⁴⁸ *Id.* at 980-982 (quoting FLA. STAT. ANN § 394.465(1)(a) (West 1992) (authorizing admittance for treatment to any adult "making application by express and informed consent" if he is "found to show evidence of mental illness and to be suitable for treatment", and quoting FLA. STAT. ANN. § 394.455(22) (West 1992) ("[e]xpress and informed consent' is defined as 'consent voluntarily given in writing after sufficient explanation and disclosure . . . to enable the person . . . to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.'")).

⁴⁹ *Id.* at 987 (footnote omitted) ("[T]he very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand any proffered 'explanation and disclosure' of the subject matter of the forms that person is asked to sign, and will be unable 'to make a knowing and willful decision' whether to consent to admission.").

⁵⁰ Winick, *Competency to Consent to Hospitalization*, *supra* note 20, at 109.

These potential social and individual costs of error do not seem present to the same extent in the voluntary hospitalization context. Nor does it present a similar potential for conflict of interest which could increase the risk of error. The costs to the individual of an erroneous hospital admission are mitigated by the fact that a voluntary patient may always elect to revoke his consent to admission at any time, thereby triggering either discharge or a formal involuntary commitment hearing within a several day period to determine the need for continued hospitalization.⁵¹

In both the treatment and voluntary admission contexts Winick assumes that the physician's fiduciary responsibilities will ameliorate the risk of error. He writes:

The fact that the physician is an employee of the treating institution does not alone create a conflict of interest in violation of due process, at least where he is independent and has a professional duty to act in the best interests of the patient, and can place his fiduciary duty to the patient over any interests of his institutional employer.⁵²

This statement is striking because the only evidence provided for the conclusion that physicians do not experience conflicts between their patients and their employers are two opinions of the United States Supreme Court noteworthy primarily for their willingness to defer to the judgment of professionals.⁵³

⁵¹ *Id.* at 119.

⁵² Winick, *Competency to Consent to Treatment*, *supra* note 20, at 66 n.93.

⁵³ The two decisions cited by Winick are *Washington v. Harper*, 494 U.S. 210 (1990) and *Parham v. J.R.*, 442 U.S. 584 (1979). *Parham* is discussed *supra* note 10. In *Washington*, a majority of the Court ruled that administrative processes were sufficient to address objections by prisoners to taking anti-psychotic medication. The Court wrote that "[i]t is only by permitting persons connected with the institution to make these decisions that courts are able to avoid 'unnecessary intrusion into either medical or correctional judgments.'" 494 U.S. at 235 (citing *Vitek v. Jones*, 445 U.S. 480, 496 (1980)).

This is not to suggest that the authors are blind to the importance of individual choice in therapeutic relationships. Winick, in particular, notes that therapeutic relationships based on the

This is not the only place in *Essays* in which the authors do not support their conclusions with empirical evidence. This lack of citation to empirical evidence is noted here principally because this is a book devoted to bringing empiricism to bear on the law. The most obvious examples occur in *Harnessing the Power of the Bet*, in which Winick argues for government sponsored wagers with citizens to achieve social policy ends. At one point, in asserting that government would have to construct different wagers for different groups of people, he draws a sweeping class-based distinction without any citation to empirical evidence. He writes:

For people with middle-class values or backgrounds, who may have a strong ability to delay gratification, the promise of a reward in the future may be sufficient to motivate present behavior. Thus, middle-class students will work hard to achieve future reinforcement in the form of good grades provided at the end of a semester and increased educational and occupational opportunities that may come many years later. Others, however, including many of the disadvantaged whose social or health problems government is most interested in solving, *often are more present-oriented, valuing present utility and heavily discounting the future. For them, the concept of future benefits may have little meaning and may not effectively influence behavior.*

Winick, *supra* note 31, at 237 (emphasis added) (footnote omitted). This statement is not only unsupported by even a single footnote, but in context gives the chapter a comparatively elitist tone, reinforced a few pages later in discussing the applicability of wager theory to drug addiction. After first reviewing a number of theories about drug addiction, Winick writes:

I can confirm much of the validity of the behavioral model of addiction out of a personal experience with drug addiction. The substance I became hooked on was cappuccino. . . . I do not suggest that all drugs function the same, of course; some—cocaine, for example—are undeniably more powerful as reinforcers than others, and significantly more addicting than caffeine. . . . Nevertheless, despite these differences and many others, the experience of becoming addicted to caffeine and that of becoming addicted to these other substances bear important similarities. Indeed, I believe that my experience with caffeine is not unrepresentative of the basic experience of becoming addicted to other drugs.

Id. at 253. Even assuming with the author that all addiction has something in common, comparing an addiction to cappuccino with an addiction to crack cocaine is a completely academic exercise. In addition, drawing a conclusion about the correctness of a particular theory of drug addiction based solely on a personal experience with caffeine in a book devoted to empiricism is an invitation to the reader to dismiss the serious points the authors are trying to make.

participation of the person subject to treatment are more likely to yield good outcomes.⁵⁴ His argument that competency generally should be presumed and deference given to the judgments of treaters is based in part on an assumption that doing so will give individuals more choice. However, the conclusion that the proposed model will expand choice rests on an idealized world where those providing treatment and those subject to it almost always reach the same conclusion, and where the clinical relationship exists devoid of economic and institutional pressures. This is *not* the world described by individuals who have written about their experiences with the mental health system.

Research has exposed the lack of voluntariness of many of the "voluntary" decisions made by people entering the mental health system and the degree to which institutional pressures distort the relationship between treater and treated.⁵⁵ It is even more interesting

⁵⁴ Winick observes that "an important rationale underlying the informed consent doctrine is that giving the patient choice in medical decision making enriches and improves the decision making process." Winick, *Competency to Consent to Treatment*, *supra* note 20, at 79-80 n.152. However, he fails to note problems that may arise in implementing informed consent principles in the context of a psychiatric-patient relationship.

⁵⁵ *But see* Susan C. Reed & Dan A. Lewis, *The Negotiation of Voluntary Admissions in Chicago's State Mental Hospitals*, 18 J. PSYCHIATRY & L. 137 (1990) (exploring the process by which a high rate of voluntary admissions is achieved). In a study of admissions to four state mental health centers, Reed and Lewis found that employees of those centers were under enormous pressure to avoid judicial hearings on people entering the centers and as a result sought to make virtually every admission a "voluntary" one. The primary pressure on employees was to continue to have beds available for new admissions—court hearings also meant time away from treatment. Reed and Lewis found that staff employed three discrete strategies to obtain a "voluntary" admission. The first was labeled "persuasion/coercion" where people were told (though it was untrue) that they would be held longer if they did not sign voluntary papers. *Id.* at 148-49. The second strategy was "barter" in which people were told that they would not have the privileges of other patients if they forced a court hearing. The third strategy was simply to stall if the person insisted on a hearing by asking the court for adjournments until the person was ready for discharge. *Id.* at 152. Reed and Lewis, who drew many of their observations by speaking with people who had been hospitalized, concluded that ". . . laws that have attempted to prevent the threatening of patients with commitment appear to have been ineffective." *Id.* at 158. Some clinicians have also recognized that informed consent is not always taken seriously by mental health professionals.

The legal requirements (for informed consent) have gone as far as they can. The framework for respect has been created and codes of

to observe how starkly different the world portrayed in *Essays* is from the world portrayed in the growing literature that is emerging

behavior have been prescribed. And that has not been enough . . .
 . Even granting the unlikely assumption that elements of physicians' overt behavior could be controlled by law, it is clear that attitudinal change must be accomplished by different means. Physicians must come to accept the values underlying informed consent before they will behave accordingly.

. . . .

Currently, physicians in residency training learn from what they see around them that informed consent is a nuisance, an alien imposition of the legal system that must be tolerated. . . .

PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 264-266 (1987).

Other factors, such as, poverty and race also affect the amount of information physicians give to patients about treatment. See 2 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 62, 97-98, 121, 124 (1982). There are also gender biases that influence the delivery of health care. Even though "women use more physician services than men, . . . physicians appear to be more likely to prescribe drugs of all types for women than for men." Ann A. Hohmann, *Gender Bias in Psychotropic Drug Prescribing in Primary Care*, 27 MEDICAL CARE 478 (1989) (footnotes omitted). See also Rachel E. Perkins & Len A. Rowland, *Sex Differences in Service Usage in Long-Term Psychiatric Care: Are Women Adequately Served?* 158 BRIT. J. PSYCHIATRY 75, 78 (1991) (discovering that a lack of "consideration of the gender-specific needs of female patients in either the planning of services or their delivery" resulted in an inadequate level of rehabilitation); Nancy G. Kutner & Donna Brogan, *Sex Stereotypes and Health Care: The Case of Treatment for Kidney Failure*, 24 SEX ROLES 279, 288 (1990) (concluding that "stereotypic views of women's and men's social needs should be considered as one of the factors, [other than "legitimate medical" factors] potentially contributing to differential kidney transplant rates for women and men."); Jane Levitt, *Men and Women As Providers Of Health Care*, 11 SOC. SCI. & MED. 395 (1977) (encouraging "change to both the sex differential in the provision of health care and the mode of practice of medicine to which it is tied" (referring to the current mode of medicine "oriented toward specialized acute care inpatient hospital treatment with priority given to high-level technology, surgery, and drug therapy." *Id.* at 397.)). It is also clear that changes in reimbursement systems are exerting enormous pressure on the relationship between physician and patient, as the cost of services must be considered more explicitly in individual clinical relationships. E. Haavi Morreim, *Cost Containment: Challenging Fidelity and Justice*, 18 HASTINGS CENTER REP. 20, 20 (1988). "Because physicians largely control healthcare resources, they are caught in a bind. Somehow they must both loyally favor their own patients, yet justly show them no favoritism as they help to distribute resources impartially." *Id.* at 22.

written by individuals who have been treated in the mental health system. This literature provides a useful counterpoint for examining some of the core assumptions of *Essays*.

Judi Chamberlin traces the roots of the consumer/survivor movement in mental health to approximately 1970.⁵⁶ Writings by people who have been patients within the mental health system suggest fundamental differences with the mental health establishment regarding priorities of need, the amount of true choice presented to people seeking or being subjected to treatment, and the amount of "helping" that occurs within the mental health system. These differences are significant and need to be examined by academicians and practitioners in the disability law field because they go to the heart of Wexler's and Winick's arguments that law should attempt to create therapeutic outcomes as defined by professionals.

Studies conducted to date show little correlation between professional identification of what people in treatment need and self-identified need. For example, in an early study, staff on a psychiatric unit viewed the gaining of "insight" on the part of people in the role of patient as the primary goal of treatment, while those who were hospitalized ranked this last in importance.⁵⁷ In other studies, professionals reported that "client resistance" was the biggest barrier

⁵⁶ Judi Chamberlin, *The Ex-Patients Movement: Where We've Been and Where We're Going*, 11 J. MIND & BEHAV. 323 (1990). Chamberlin describes the establishing principles of the ex-patients' movement which include the exclusion of non patients, consciousness raising, and self help and empowerment. *Id.* at 327. In recounting the history of people formerly treated by the mental health system establishing a movement of their own, Chamberlin distinguishes between "mental patients' liberation" and "anti-psychiatry." Chamberlin describes the latter as "largely an intellectual exercise of academics and dissident mental health professionals . . . [who have made] little attempt . . . to reach out to struggling ex-patients or to include their perspective." *Id.* at 324. Chamberlin provides valuable insights into the history of the "ex-patients" movement, and notes the differences of view among those in that movement devoted to "a basic liberation principle [is] that people *must* speak for themselves" and a reformist "consumerism which developed as the psychiatric establishment began to fund ex-patient self-help." *Id.* at 333-34. See generally JUDI CHAMBERLIN, *ON OUR OWN* (1978).

⁵⁷ Joel E. Dimsdale et al., *Conflict in Treatment Goals Between Patients and Staff* 14 SOCIAL PSYCHIATRY 1, 3 (1979) (confirming that "patients and staff operate on very different wavelengths as far as their ideology about goals for therapy . . ." especially concerning insight); see Priscilla Ridgway, *The Voice of Consumers in Mental Health Systems: A Call for Change*, A PROJECT OF THE CENTER FOR COMMUNITY CHANGE THROUGH HOUSING AND SUPPORT, University of Vermont, Dec. 1988.

to service utilization by a group of 286 people in community treatment, with financial issues and transportation being ranked much lower. In contrast, 100% of the people in treatment reported that financial problems were the biggest barrier to utilizing service and obtaining necessary supports, with transportation and the lack of availability of services also noted as major problems.⁵⁸ Similar findings have been reported comparing consumer and professional opinions regarding housing.⁵⁹

These studies are important because they suggest that mental health professionals and people treated by them view need in fundamentally different ways. This suggests in turn that the idea of choice presented in *Essays* is for many people a false one: even where autonomy is preserved in an individual therapeutic relationship, the universe of choices available to a person often does not include the very things identified as most pressing.

People who have undergone treatment in the mental health system also report a much less idealized experience than that imagined in *Essays*. One unpublished report, summarizing interviews with forty-six people (including thirty-four who were former or present consumers) notes that "while respondents cited a variety of sources of stigma, *most frequently mentioned were the attitudes and*

⁵⁸ See Mary M. Lynch & Jean M. Kruzich, *Needs Assessment of the Chronically Mentally Ill: Practitioner and Client Perspectives*, 13 ADMINISTRATION MENTAL HEALTH 237 (1985) (discussing the confusion regarding the types of services required to enable the chronically mentally ill (CMI) to function independently in the community).

⁵⁹ A study of client housing preferences revealed that three-quarters of a hospital staff believed that individuals in their care required highly structured housing while only one-quarter of those hospitalized wanted such housing. Phyllis Solomon et al., *A Comparison of Perspectives on Discharges of Extended Care Facility Clients: Views of Families, Hospital Staff, Community Mental Health Workers, and Clients*, 15 ADMIN. MENTAL HEALTH 166 (1988) (reporting study results that a majority of mentally disabled persons confined to institutions prefer solitary and independent living conditions upon discharge, in contrast to family and staff concerns that released clients would not be able to control their own behavior in that type of setting). See also Howie T. Harp, *Taking Issue: Taking a New Approach to Independent Living*, 44 HOSP. & COMMUNITY PSYCHIATRY 413 (1993) (describing the desire of "most consumers of mental health services" to live independently); Priscilla Ridgway & Anthony Zipple, *The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches*, 13 PSYCHOSOCIAL REHABILITATION J. 11 (1990).

practices of the mental health system and its workforce."⁶⁰ Interviewees characterized a number of specific practices as stigmatizing, including issues of power and control particularly: forced treatment and its threat, reinforcement of the point of view that people in the role of patient had lower status than professional staff, forced separation in many mental health programs of people with psychiatric disabilities from ordinary community life, the absence of challenge or an orientation to personal growth in the mental health system, and a pervasive lack of privacy.

Some former patients have recounted in personal terms the sense of powerlessness which accompanies the onset of serious psychiatric illness. This powerlessness is often reinforced by the mental health system. Two of these accounts are quoted at some length, because they challenge the core premise of *Essays* that researchers, practitioners, and lawyers, working in concert, are capable of defining and implementing therapeutic values.

Patricia Deegan, a nurse, recently described her reactions as she was being told by her doctor that she had been diagnosed as a chronic schizophrenic.⁶¹

I remember that as these words were spoken to me by my psychiatrist it felt as if my whole teenage world—in which I aspired to dreams of being a valued person in valued roles, of playing lacrosse for the US Women's Team or maybe joining the Peace Corp—began to crumble and shatter. It felt as if these parts of my identity were being stripped from me. I was beginning to undergo that radically dehumanizing and devaluing transformation from being a person to being an illness; from being Pat Deegan to being 'a schizophrenic.' As I look back on those days I am struck by how all alone I was. This profound sense of being all alone only served to compound my sense of

⁶⁰ Deborah E. Reidy, "Stigma is Social Death": Mental Health Consumers/Survivors Talk About Stigma in Their Lives. Education for Community Initiative (Feb. 1993) (unpublished manuscript on file with author).

⁶¹ Patricia Deegan, *Recovering Our Sense of Value After Being Labeled Mentally Ill*, PSYCHOSOCIAL NURSING, Apr. 1993, at 7.

feeling worthless and of having no value . . . in a very fundamental way I experienced myself as being all alone, adrift on a nameless sea without compass or bearing. And that deep sense of loneliness came from the fact that although many people were talking to me about my symptoms, no one was talking to me about how I was doing.⁶²

Betty Blaska describes in *her* account the lack of power and autonomy that characterizes the daily lives of many people treated for mental illness.⁶³

The first time you experience dystonia from the neuroleptics they've given you, you're extremely frightened. Your tongue is rigid and you're unable to control its movements. You rush to the nurse's station and they're all huddled inside the little cage's protective walls. They won't leave it for fear of contamination. They are puzzled by your presence and seem greatly inconvenienced by it. You can't speak because of your tongue's movements. Yet they wait impatiently for you to tell them what's wrong. And you wonder what's wrong with them. Can't they see your predicament? But, no. It's not that they don't see. They don't feel. Because you don't count. You're on your way to becoming a CMI.⁶⁴

Blaska continues a description of her experiences:

As an inpatient in what's called a 'mental institution' you go to something they call OT—occupational

⁶² *Id.*

⁶³ Betty Blaska, *First Person Account: What It Is Like to Be Treated Like A CMI* 17 SCHIZOPHRENIA BULL. 173 (1991).

⁶⁴ *Id.* Blaska uses "CMI" as shorthand for "chronically mentally ill," the label often applied to people who have been treated more than once or for more than a brief period of time for mental illness. Blaska uses the acronym to reinforce the depersonalization experienced by many people treated for mental illness, who often become known more frequently by a label attached by others than by their name.

therapy. Everything here is called therapy—even when it isn't. And today it's 'assertiveness' class! Whoopie! Someone back in the 1960s decided that the hallmark of a mentally healthy person was being assertively able to choose and refuse, speak, act, and listen. This is a mockery inside a place called a "mental institution" because here no mental patient is free to choose, refuse, speak, or act. You can't even listen to each other without someone spying, reporting, recording, and charting. And then calling you paranoid if you notice. Or object.

And when you refuse an activity or "therapy"—which they tell you is your right—and which they've taught you to do in their 'assertiveness' class, then they badger you by sending nurse after nurse, attendant after attendant, into your room to remind you that "It's 1:00. Time for OT!" Your refusals mean nothing. They badger you until you either give in and go, or they've frustrated you to tears. Or enraged you to anger. And then they can justify calling you by the malignant label they've designated you by—resisting treatment or "noncompliant," passive dependent, passive aggressive, paranoid, or borderline personality disorder. They're all different labels. But they all mean the same thing: you're not really you. You're just a CMI. And that justifies their dehumanization of you.

.....

And of course you've lost your job. Who could work amid all this drug experimentation? And the myriad of drug side effects—nausea, diarrhea, dizziness. Vision so bad you can't cross the street because you can't judge the cars' distance from you. Drug-induced psychosis so bad you can't leave your bed or look out the window for the terror you feel. Blood pressure so low you can't stand for very long,

and your voice so weak you can't be heard across a telephone wire.⁶⁵

In recent years, some professional attitudes have begun to change—in the last few years, particularly with the growth of the psychosocial rehabilitation movement⁶⁶ and services designed by consumers,⁶⁷ some mental health services informed by true respect for individual autonomy and choice have emerged. However, we professionals who make our livelihoods and careers in mental disability law often fail to seek the opinions of those most affected by the work we do. Legal decisions often devalue individuals who have been labeled mentally disabled, and often mask stereotypical views of those who are disabled.⁶⁸ Yet even public mental health systems have created formal roles for consumers,⁶⁹ and, in general medicine an

⁶⁵ *Id.* at 174-175.

⁶⁶ The psychiatric rehabilitation movement is a philosophy of treatment which explicitly seeks not only the participation of the person diagnosed as mentally ill in treatment but looks to the person to be primarily responsible for designing the goals and substance of the treatment process. It also seeks to combine social supports like case management and housing with more traditional medical treatment. WILLIAM ANTHONY ET AL., *PSYCHIATRIC REHABILITATION* (1990); WILLIAM ANTHONY, *PRINCIPLES OF PSYCHIATRIC REHABILITATION* (1979).

⁶⁷ See, e.g., Judi Chamberlin & Joseph A. Rogers, *Planning a Community-Based Mental Health System: Perspective of Service Recipients*, 45 AM. PSYCHOLOGIST 1241 (1990); Judi Chamberlin et al., *Consumers, Families, and Community Support Systems*, 12 PSYCHOSOCIAL REHABILITATION J. 93 (1989); Esso Leete, *A Consumer Perspective On Psychosocial Treatment*, 12 PSYCHOSOCIAL REHABILITATION J. 45 (1988); HOWIE T. HARP, NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH CONSENSUS VALIDATION CONFERENCE ON STRATEGIES TO SECURE AND MAINTAIN EMPLOYMENT FOR PEOPLE WITH LONG TERM MENTAL ILLNESS, *EMPOWERMENT OF MENTAL HEALTH CONSUMERS IN VOCATIONAL REHABILITATION* (1992).

⁶⁸ See Michael L. Perlin, *On "Sanism"*, 46 SMU L. REV. 373, 376-77 (1992) (urging a total restructuring and re-education of counsel, judges and legislators, "both substantively and attitudinally" to eliminate bias against mentally disabled persons especially in the drafting of statutes or writing of opinions). Cf. Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of 'Ordinary Common Sense,' Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. ACAD. OF PSYCHIATRY & L. 131 (1991).

⁶⁹ A report by the National Association of State Mental Health Program Directors (the association of state commissioners of mental health) reported that 65% of state mental health agencies provided at least some financial support for consumer-run and family-run programs (the family and consumer/survivor movements are separate

influential body of work is emerging which relies principally on the reports of patients in assessing the quality and effect of medical interventions.⁷⁰

Essays, however, like most of the mental disability law literature, is virtually devoid of any reference to experiences like those recounted above, or to the literature that suggests that the people providing treatment and the people receiving it may have fundamentally different views on questions of need and whether the mental health system is in fact infused with therapeutic values. This is not a minor point, because *Essays* depends on a particular point of view about the way in which the mental health system works. That point of view is in many ways highly idealized, and assumes the existence of choices that often simply do not exist. It is ultimately paternalistic, because it honors autonomy as a value only until professionals decide that other values should triumph. It holds therapeutic jurisprudence subordinate to constitutional values but reinforces the existing distribution of power between professionals and people with disability. Until these issues are confronted directly, in therapeutic jurisprudence specifically and in mental disability law generally, the promise that the theory of therapeutic jurisprudence has for reinvigorating mental disability law will go unrealized.

movements in most respects), and that 19 states had established consumer offices or had definite plans to start such an office. National Association of State Mental Health Program Directors Studies, Survey #92-720, (Mar. 22, 1993).

⁷⁰ E.g., *New Patient Preference Tools Force Tough Choices*, 4 REP. MED. GUIDELINES & OUTCOME RES. 1,2 (1993). Dr. Robert Nease has developed a computer program to assess the tradeoffs people with angina are willing to make when presented with competing treatment choices. Such information will be used in the development of practice guidelines, which to date have been developed with little information about patient choices. See, e.g., Bob Curley, *Managed Care Study to Examine Outcomes and Satisfaction*, MENTAL HEALTH WEEKLY, Aug. 24, 1992, at 4 (announcing the use of "the Health Status Questionnaire (SF-36) and a self-evaluation instrument to measure quality of life and improvement in symptoms" by a managed care company to measure satisfaction (by clients) with its services).

